Expert Advisory Committee
Tuesday May 29, 2012
Meeting Minutes
8:00am – Healthcentric Advisors

Attendees: Lou Giancola, Jay Raiola, Ted Almon, Joan Kwiatkowski, Beth Lange, Dan Meuse, Deb Faulkner, Sandi Ferretti, Lindsay McAllister, Elizabeth Earls, Kathryn Shanley

I. Call to Order – Dan Meuse called the meeting to order at 8:00am. At our last meeting we had a discussion about the exchange being and active purchaser and left it open about what it may want to purchase. This is a follow up conversation on selection of Qualified Health Plans. A few reminders, when we discuss plans here it is specific insurance things that you buy. Plan is a product not a company. An issuer is a company.

II. Selection of Qualified Health Plans (QHP's) to offer on the Exchange [Presentation by Dan Meuse, slides available on website or by request].

Questions/Comments/Clarifications:

a. Lou Giancola: What do we mean by "active" purchaser.
    i. Dan Meuse: There is a dichotomy between being an active purchaser where it sets criteria and specific needs, vs. an open market where we just give general standards, baseline and the plans can take their form from there.
b. Kathryn Shanley: Are there any qualifications for the issuers or is it strictly the product?
    i. Dan Meuse: A few different distinctions the state has the chance to determine. There are the state licensing and state requirements to begin with, but there is an outstanding question among the regulatory agencies as to where the QHP regulatory may authority rest.
c. Ted Almon: Where are we on the rest of the public employees?
    i. Dan Meuse: It is unclear because of how our request for funds was made. The amount to which public employees would be able to leverage the exchange prior to 2017. The exchange is an infrastructure platform and the exchange itself if it were stand-alone could not accept public employees until 2017 as it is technically a large employees. If we had an extra year or two to build the exchange and could have the state give input as it may be more efficient to have the public employees in the exchange, then that is another story.
    ii. Ted Almon: Need bodies in that system, which is why I ask. As a large employer I could give my employees the money and let them go through the money couldn't i?

iii. Dan Meuse: Not exactly – you would normally effectuate that process through a section 125 contribution to an employee, and specifically section 125 contributions may not be used on the exchange.
iv. Ted Almon: Right but I could give the employee the funds any way I want?
v. Dan Meuse: Right, and still preserve the tax-exempt status of those dollars. That is the rub, how that goes through.

d. Ted Almon: How are the multi state plans going to negotiate with providers?
    i. Dan Meuse: We do not know yet; we have been pushing our federal partners to consider multi state products need to meet state standards. Office of Personal Management (OPM) has been very unclear with how that will play out, but RI has been very aggressive in its push to bring guidance, but guidance that will have multi state plans meet the standards.

e. Ted Almon: Could the exchange offer a private label, could it specify the coverage it wants put that out to bid, select a winner and put it out there as what it is?
    i. Deb Faulkner: Yes, that is one option – see future slides.

f. Lou Giancola: And you are trying to balance acceptability to the consumer with your hope to bring about change. Have you come to conclusions about what sort of change would you like to bring about and which option that is, multiple plans, or fewer plans will aid in that goal?
    i. Dan Meuse: that is part three of today's discussion and we are just starting in on part two. One thing important tot the state, everyone who is trying to do something with health insurance is trying to dot hat same thing. IOHIC has great affordability standards and we are hoping to see more adherence to that. There would be a desire to not do anything that is in conflict, but I think that there are still some specific areas that the exchange may want to push forward on, and we can talk through those and see what those may be.
    ii. Deb Faulkner: And I think some of it is a question of what we do first, over time we expect that we would evolve this model. We can learn from say stage one and re-align as we go alone. Want to pick a few things that are priorities and move to those. Today we want to talk about what are the areas that we want to work towards, what are the priorities.

g. Jay Raiola: The first thing you have to keep in mind in terms of the plans you have to offer you will still be tied to having the plan on the bottom end meeting the minimum credible coverage. That is where you start – want to be as flexible as possible in all markets. In the last two years every quarter brand new products are hitting the marketplace. I believe we want this exchange to be out there, to know

what these new products are, so we can compete with the outside marketplace, looking at if new plans are what we need – so much changing so quickly, do not want to hand tie oneself. I fall more to the laissez-faire end of this.

h. Elizabeth Earls: I am wondering though, what are quality measurers in terms of what consumers want for their coverage.
    i. Dan Meuse: I think that the staff recognizes that both of these models have problems, and that we will not have agreement across the board. Thus we a removing into the slide with three different models that fall between these two that hopefully we can find more agreement around.

i. Lou Giancola: When you say plan design you are talking about the benefits as opposed to the reimbursement elements that impact how providers behave? And I think that is the problem I have with adopting to the innovation of the month strategy, as it would negatively impact providers who are trying to adopt to meet new plans, as opposed to learning and going.
    i. Dan Meuse: There would potentially be an opportunity to say that we want tot see a drive at the issuer level of a difference in how you structure your payments, or a difference in how you pay for care. Perhaps that can be evaluated, perhaps it can be a principle of innovation, and you can prove to regulators or the exchange and move innovative payment models.
    ii. Lou Giancola: Do we have any sort of comparisons to make with what Massachusetts have done?
    iii. Deb Faulkner: I can say on the exchange side the way they have done it is different for each of the segments they serve. They have their subsidized and unsubsidized populations under different programs, which the ACA will not allow for. The subsidized program they started with so setting some requirements and move to setting plan designs. Similarly have set to setting plan designs in the individual make themselves – not the case in small group markets. The challenge then is how people compare options, but on the other hand do not want to discount innovations. The conversation we hear from MA is that it is difficult when you do not standardize, but perhaps every market needs different options, or perhaps just evolve as we go along.

j. Ted Almon: On the recommendations for options – we all recognize that there is a drive between profit and benefit, there is no question that the amount of innovation done in an open marketplace would have enormous complexity, and it is unclear that this time as to at what point complexity outweighs the benefits. There is a thread of that hat goes through this whole reform, through single payer, the exchange is potentially a single purchaser, it will have an impact on the market. I feel a part of it may be that have the so-called

innovations actually helped bend the cost curve or not. I think that the coordinated health planning piece is perhaps the critical point of this whole exchange discussion, decide what the scope of the at health planning body will be and how it will interact with exchange governance and board in order to determine where on this selection spectrum we should be.

k. Elizabeth Lange: By definition the polar extremes cannot be the norm, as it could potentially alienate innovation on either extreme. I feel we need to be somewhere between plan define and exchange define. Is the tipping point somewhere between those two?
    i. Dan Meuse: I go back and forth on the evaluative method, on whether it should be evaluate on innovation or the exchange denied innovation options. Perhaps if that teeter-totter is between the middle and the exchange defined options the fulcrum is evaluating now, and providing guidance to consumers.
    ii. Elizabeth Lange: I think going off of what Lou said is that United has hundreds of plans and providers do not know what they are working with immediately, and the idea of more of that is really concerning, as that will increase administrative time, and that is more cost shift.

l. Kathryn Shanley: From an issuer perspective, anything in the middle is like saying someone is a "little bit pregnant" – either you are you aren't. I feel extremes allow for definition, and ease of understanding the roles, and perhaps then innovate down the line.
    i. Lou Giancola: I think you do know your business which is basically to satisfy the customer, but the issue is total health care cost, I think, and I don't know where on the spectrum we should be, but I think that we do need to be paying attention to how we are controlling cost overall. Ultimately that is what will make a difference in society. Secondly, we have some evidence as to what drives consumers, and we ought to build in as much of that as possible. A 10% difference in co-pay will actually allow that to happen, then we need to build those things into design as well. It would be silly to ignore that. We are beginning to understand what providers do that make a difference, and for sure out to be able to incent that etc. I would hope that we should build in the evidence-based incentives for people who use care.

m. Ted Almon: To me that is exchange defined innovative options.
    i. Dan Meuse: These are not discreet, there is something in between that fourth and fifth that the exchange may offer QHP's, may need to incent better transitions of care, and those may more visible to the consumer.
    ii. Deb Faulkner: What need to establish on a state level how much should be at the exchange level, what needs to be tested

at a state level, what should be state level, and what should be tested so we can share that appropriately.

n. Lou Giancola: One thing that comes to mind is that the last IOM said we need to merge public health, and I don't know where that comes to play in this discussion. There is an opportunity to plug that into this discussion.
    i. Deb Faulkner: I agree, haven't quite figured out how we translate those objectives into the regulatory model, we have to continue to look at that – keep looking at Vermont and how they have managed this.
o. Ted Almon: Do they have coordinated health planning somewhere in Vermont?
    i. Deb Faulkner: I believe they do.
        1. Ted Almon: To me that is what I hear from you, Lou, that seems to be what you are discussing, letting coordinated health planning discussion.
        2. Lou Giancola: But the authority doesn't exist – we have two hospitals in receivership now in the state and that process is divorced from the health planning process – so not finding this inclusive network that may actually be able to move things forward.
p. Jay Raiola: I pray that the individual mandate stays in tact, because I am not sure what you do and do not like in Massachusetts, Deb. I question daily what Romney is doing now and why he doesn't take credit for what he has been doing – MA has a great exchange, great carriers, and great products with a model to adjust as moving forward. Believe that all stems from individual mandate, and I am really focused on what happens of the Supreme Court adjusts that.
    i. Ted Almon: Even if it gets blown up on a national level, then it goes back to the states and RI can push it's own through the line.
q. Dan Meuse: Would like to talk more about types of innovation now, as we enter the last few minutes of our meeting.
r. Elizabeth Lange: Just would like to point out that some plans are now offering a retail based clinic as opposed to a medical hoe and that is a disincentive to come back to medical home for primary care– just wanted to put that on the radar.
s. Lou Giancola: Just pausing on minimum outcome standards on this list, you would say to an issuer that you have to have minimum outcomes?
    i. Dan Meuse: Perhaps a minimum outcome could be preventable readmissions, or perhaps it could be outcomes for care transitions, start a process.
    ii. Kathryn Shanley: For an insurer you can do all these things but if people do not behave, you are still left hanging out there.

iii. Elizabeth Earls: Plans partner or working with consumers and issuers and providers can aid in this, and perhaps minimum outcomes are a way to go.
iv. Dan Meuse: Next steps are to bring this to the Board and perhaps develop.

t. Elizabeth Earls: Where does the work of the EHB work group fit into all this?
    i. Dan Meuse: One of the minimum requirements of a QHP is that it folds in EHB. There is a link and I think that what we are speaking about in the QHP selection is less about specific covered services and more about how those services drive the market in the right direction. These get braided together in the next couple of months.

u. Lou Giancola: We certainly have come down from 50,000 feet to 10,000 feet. But we know certain things about health access and utilization in RI versus other states – are we going to prioritize on the utilization and cost control side the elements that we particularly want to attack, and then on the quality side we know some things that we want to work on and are we going to bring it down to that level or is it too politically charged to told that into plan design?
    i. Deb Faulkner: I think that is where we decide – we can be very vague or very specific.
    ii. Lou Giancola: You can do some of this stuff from plan design, I worry about that – as opposed to payment reform which incents providers to reform their behavior.
    iii. Elizabeth Earls: I share that concern, I want to get the consumer pointed in the right direction.
    iv. Deb Faulkner: I think that the exchange has more control over plan design and the stretch of authority may be more limited.

v. Ted Almon: As limited network products are introduced there are employers who will be inputting that. Transition into individual choice.

w. Jay Raiola: Which department will be in charge of certifying minimum credible coverage? No 1099 will be issued unless the plan meets the MCC, but the employer can bring that out.
    i. Deb Faulkner: I think there are a few layers there, a lot of the plan designs that many individuals are involved in the state doesn't have s ay in as they are out of state plans. We are pushing for some sort of a database of plans so that we can capture this information. We have not yet decided which entity will handle this point, I believe that OHIC and the Exchange will talk in future to figure out where that lies.
    ii. Dan Meuse: We do not know how an employee is going to come and say here is my benefit package, here is the cost, does that meet MCC.

iii. Jay Raiola: If there is a plan that is sold to an employer then no 1099 is sent out, this could lead to disgruntled employees – need to make controls tight.
iv. Dan Meuse: Good thing is that nothing sold on the exchange can be below minimum value.
v. Angela Sherwin: The goal is that in MA both the department of revenue, the connector and DOI have a hand in the pot at some time.

III. Public Comment - No further comment

IV. Adjourn